The Hampden Hippocrat

MAY, 1974

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HDMS PRESIDENT
1974 – 1975

HAMPDEN DISTRICT MEDICAL SOCIETY

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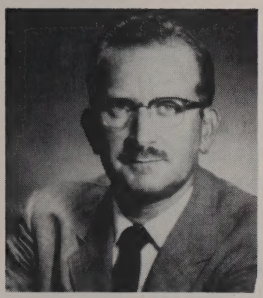

Your President's Page

Greetings: To the HDMS Membership!

I consider it a great honor and privilege to serve as President of the Hampden District Medical Society during the coming year. As it is well known, the Hampden District Medical Society is one of the most highly respected of all the districts in the state.

We find ourselves in the midst of difficult times, what with PSRO's being the law of the land and Washington readying a National Health Insurance Plan which is expected to take effect by 1976 at the latest. We must have input into the AMA's and Mass. Medical Society's sponsored efforts to modify and amend the PSRO law and regulations as it now stands. Repeal is extremely unlikely; modification and amendment is practically certain if we all put our shoulders to the wheel and work together. There is need to modify the concept of Professional Standards Review Organization to "Peer Review" so that the leadership and control remains in the hands of physicians and *NOT* in those of government bureaucrats or health care professionals other than physicians!

I should also mention that I feel overwhelmed by the responsibilities that go with the job. The presidents who preceded me have served with such great distinction that I can hardly hope to match their skill, effort and accomplishments. Moreover, I am fully aware, as every one of us all are, that the times we live in are critical and turbulent, especially for our profession. The only way we can expect to cope with all the problems confronting us today is to continue to work together as we have in the past. And even more so! There is, of course, always room for improvement. Ways and means must be found to stimulate the interest of all members, and especially of the younger members, in our society's affairs. The future of medicine, needless to say, belongs to those of our members in their 30's or early 40's.

I also believe that we should become involved more and more in community health matters. Other societies have conducted anti-tobacco campaigns, profloridation projects, and hypertension programs and there is no reason why we shouldn't embark on one or more of these or other worthwhile projects.

I also believe that our committees are deserving of much more support and recognition than they received in the past. I firmly believe in the old saying that officers "may run a society but it is committees that make it." As a member-ex-officio, I hope to attend as many committee meetings as possible. Committee chairmen should be encouraged to report to the society at frequent intervals and their reports should be published prominently, frequently and regularly, in the *Hippocrat*.

(cont.)

YET I ARGUE NOT, AGAINST HEAVEN'S HAND OR WILL, NOR BATE ONE JOT OF HEART OR HOPE; BUT STILL BEAR UP AND STEER. RIGHT ONWARD!

John Milton

We will be asking for members to volunteer their services to work on the many committees in our organization. I would appreciate a phone call or note sent to the HDMS' office expressing interest in a specific committee and we will transmit the information to the various committee chairman for appropriate action.

Again, as a past chairman of the A.M.A. Membership Committee, I urge those HDMS members who do not belong to join the AMA. Our letter to non-members, resulted in over a dozen new membership applications and it is hoped this trend continues. The HDMS benefits in many ways as does the new member. One of the new positions now open is that of chairman of the AMA Membership Committee! Please contact me and we'll get rolling toward better AMA representation among our membership.

Speaking of committees, I now appeal to all committee chairmen *NOT* to wait until next fall before calling the first meeting of their respective committees. The time to do it is *NOW* before the warm weather and vacation season is at hand. In these pressing and rapidly changing times we simply cannot afford to wait!

And finally, I hope that every member of our medical society will feel free to come to me with any suggestion that might benfit our organization in one way or another. Be assured that whatever the suggestion, it will receive due and proper consideration.

Thank you for your confidence and support.

Bernard Bloom, M.D.
President 1974-75

* * *

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Highlights of the Annual Banquet and Meeting 1974

The Annual Meeting of the HDMS was held on Tuesday, April 30, 1974 at the Stagecoach Barn at Storrowton Tavern in West Springfield. A quorum of fifty was established at 6:15 P.M. and the meeting was called to order by President Setrag Zacarian.

There were 147 reservations, 134 attended, nine without reservations; 22 men made reservations but did not attend.

The Secretary read the minutes of the February meeting, and they were approved as read.

The Annual Committee reports were approved as printed in the Hampden Hippocrat.

The By-Laws Committee had a report with a recommendation. Therefore Dr. Memery presented the amendment to the By-Laws; refer to Chapter VII—Committees Section 19—Medical Charges and Peer Review Committee. Dr. Memery first asked to have the paragraph concerning the Reserve Subcommittee deleted. This was approved. Discussion of the results of this change followed. The By-Law change was amended to have the President-Elect indicate the names of the members of the Medical Charges and Peer Review Committee with the approval of the Chairman. An affirmative, almost unanimous vote resulted.

Dr. Eugene Boss, Jr., gave an updating of the work that his committee had done this past year, i.e. an Arbitration Plan for the HDMS and the Hampden Bar Association. This plan has been presented to the insurance companies for further study. It is hoped that a final positive report will be given in the fall.

Dr. LaMarche, President of the Western Massachusetts, PSRO, Inc., gave the latest information about the PSRO designation Area 1.

Dr. Moore, Treasurer, presented the financial statement for the past year, 1973-1974. The motion was made that the dues remain the same for 1974-1975. Dr. Simpson, Chairman of the Auditing Committee presented a report stating that the books of the HDMS were in good condition and moved to have the report accepted. It was so voted by the membership.

Mrs. Purdy reported that Dr. Harry Roberts was in the hospital and had asked to make two announcements about Golf Days. HDMS Golf Day will be on July 17 at the Twin Hills Country Club and the Springfield-Mercy Hospital Golf Day will be at the Longmeadow Country Club on . . . . . .

After motion duly made and seconded, the meeting physicians voted to adjourn for the Social Hour, and dinner.

After reconvening, Dr. Zacarian read the names of seven physicians who had passed away during the past year and asked for a moment of silence. (cont.)

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Dr. Zacarian introduced the head table, Dr. Paul T. Moore, Treasurer, Dr. Robert Kelley, Chairman of the Nominating Committee, Dr. Augusto G. Asinas, Public Relation Councilor, Dr. Walton E. Stevens, Secretary and Mrs. Vivian Purdy, Executive Secretary.

Our President presented a fifty year in medicine Golden Certificate to Dr. Honore Gaudreau. Others in medicine for fifty years are Drs. Robert Loring, Walter Wiese and Harry Roberts who were not present. Dr. Gaudreau made a few appropriate remarks and ended with a quotation, "When I am right no one remembers, when I am wrong, no one forgets."

The President introduced the various past Presidents who were honored at this time.

Dr. Zacarian introduced Dr. Asinas, Public Relations Councilor who presented plaques to Kitty Broman of WWLP, Durham Caldwell of WHYN and Keith Silver of WWLP for their outstanding contributions to the better understanding of HDMS medicine during the past year.

The Chairman of the Nominating Committee, Dr. Robert A. Kelley presented the slate of officers for the ensuing year. (SEE NEXT PAGE) There were no nominations from the floor and it was moved, seconded and voted to accept the slate as presented and the Secretary was instructed to cast one final vote for the nominations. It was so done.

A special gift was presented to Dr. Paul T. Moore, Treasurer for his faithful service as Treasurer for 10 years. A gift was also presented to Dr. Donald R. Hayes for his long term as a member of the House of Delegates of the AMA and his continued service on the Council on Medical Service of the AMA.

Dr. Zacarian gave his farewell to the members as the President and presented Dr. Bloom with a miniature telephone for all the problem telephone calls that will be coming his way during the present year. Mrs. Purdy was presented a gift by Dr. Zacarian for her usefulness during the past year.

Dr. Bloom gave his acceptance speech and indicated that committee members will be printed in the Hampden Hippocrat shortly.

The meeting was adjourned at 9:30 P.M.

The Secretary called a meeting of the present Councilors to elect an Executive for the year ahead. Dr. James Allan was unanimously elected as Executive Councilor and Dr. LaMarche was elected as Alternate Executive Councilor.

Respectively submitted,

Walton E. Stevens, Secretary

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Annual Meeting of Hampden District Medical Society
Annual Meeting—April 30, 1974 at Old Storrowtown Tavern

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VICE PRESIDENT
PRESIDENT ELECT
Gardner Cox, II
SECRETARY
Carl W. Janovsky
TREASURER
Paul T. Moore

COMMISSIONER OF TRIAL
Alfonzo A. Palermo
SUPERVISING CENSOR
Malcolm S. Allan (five years from 1972)
CENSORS
(Not more than 4 years)
John J. Burke, 1972
John J. Flahive, 1972
Robert A. Sears, 1972
James H. Mahoney, 1974

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James D. Allan, Executive Councilor
Malcolm S. Allan, Supervisory Censor
Augusto G. Asinas, Public Relations Councilor
Maurice J. Boivin, Legislative Councilor
John C. Ayres, President of MMS, Ex-Officio
Allen S. Johnson, Past President MMS, Ex-Officio
Lorne C. Smith, Chairman Insurance MMS, Alternating, Ex-Officio
Carl W. Janovsky, Secretary, Nominating, Ex-Officio
Bernard Bloom, President HDMS, Ex-Officio
W. Max Cloud
Gardner Cox, II
Louis F. Derose
Enzo V. DiGiacomo
Donald G. Fahy
John F. Griffin
Garry DeN. Hough, III
Joseph R. Kelly
Robert N. LaMarche, Nominating Councilor
Paul T. Moore
Leo S. Newman
Terry D. Ryan
Frederick C. Schwendenmann
Walton E. Stevens
Bruce B. Stoler
Emanuel Weidman
Setrag A. Zacarian

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NOMINATING COUNCILOR
Robert N. LaMarche
ALTERNATE NOMINATING COUNCILOR
Lorne C. Smith
EXECUTIVE COMMITTEE
Stanley N. Teale, 1977
Lorne C. Smith, 1977
Robert A. Kelly, 1976
Edward I. Kraus, 1976
William J. Cummings, 1975
Sheldon S. Goldberg, 1975
Setrag A. Zacarian, Past President
Augusto G. Asinas, Public Relations

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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ARTICLE: Health Care of the Poor and Elderly

Circumstances are such that here in the U.S. all of us are affected by those who are classified as poor or elderly and who suffer because of socio-economic reasons from inadequate efforts in the delivery of health care. Paramount reasons why recipients receive poor health care are:

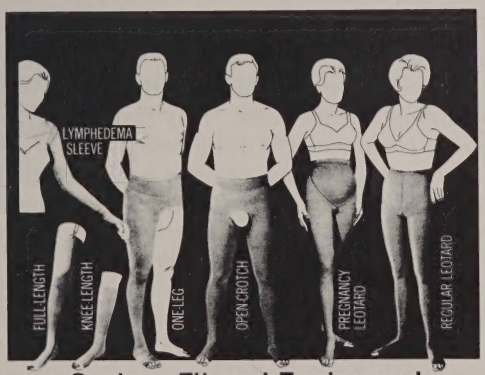
1. Lack of sufficient health care facilities and programs in certain areas.
2. Lack of information about how to obtain adequate health care in the existing system.
3. Inadequate education, language, cultural and ethnic problems which contribute to inadequate health care.

This article is an attempt to express some *opinions* obtained from representatives of the poor, the social agencies and organizations concerned with programs designed to assist in meeting the health care needs of the poor and, in many cases, of the elderly as well.

Because of the attendent social ills existing in the poor communities such as poor housing, malnutrition, unemployment and inadequate education, (problems which breed attitudes of despair, misery and degradation) the health problems of the poor are more severe than in other areas and consequently the restoration of normal health is made enormously more difficult. Besides the poor, the geriatric population has grown faster than the services available to them. Many of our elderly live in desperate circumstances; many who are too ill to do much for themselves except merely exist have no one to visit or even look in on them from one week to the next.

The intent of this article is to re-emphasize some of the contemporary problems most often experienced by the poor and elderly and also to afford an opportunity to those who are knowledgeable about their needs to express their concern to us, the medical profession.

(over)



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Available Health Care Services

There are several social agencies which have been funded by the municipal, state and federal governments to assist in the delivery of health services and it is alleged that they are not properly utilized by the physicians and that some of the physicians are not adequately informed of their existence and function.

Four of the agencies are:

1. The Home Care Corporation; funded by Model Cities it furnishes a variety of services for those sixty or older in Health care, transportation, legal aid, nutrition, house chores, etc. Located in the Municipal Hospital Bldg. the Home Care Corp. has approximately 4 case workers for an estimated 21,-000 persons stated to be 65 or over in the city. The bulk of the poor and elderly in the city are from essentially three census tracks: North End, South End and Winchester Square areas. Of these three, the South End and Winchester Square make the fewest requests for health services, yet they represent the areas that need the service most. This lack is thought to be due to an unawareness of services available, on the part of the patient and physician, poor information dissemination, cultural lag, and welfare stigma.
2. Visiting Nurse Service whose offices are adjacent to the Home Care Corp. will be discussed in more detail below.
3. Child and Family Service; services available to all, limited funds in offering home care services, counseling and multiple other social services.
4. The Urban League: recent additions to their programs include transportation, seminars and education programs in health education.

These agencies assist in the supportive care and the follow through of services which are essential and in some cases indispensible in the care of the poor and aged.

Visiting Nurse Service

A constructive criticism is the failure of the medical profession to use appropriately the services of the visiting nurse service. The physicians' services may be supplemented in many cases and particularly for the people who do not understand the "system" for obtaining medical care. This inevitably results in the patients coming to the emergency room with the usual complaints of "waiting too long and nothing being done" when in fact most of these patients should not be in the ER delaying services for those who are in greater need and preventing adequate service from being given to those acutely ill. If earlier referrals to the visiting nurse service were made on a regular rather than a crisis basis their services would be more comprehensive. It has been suggested that the VNS might have one of their nurses visit the patient prior to discharge and be followed after hospitalization. Another concept is that a VN serve as a liaison on the Utilization Committee in the hospital. This is currently being done in three cities in the Commonwealth. It would assist in the maximum utilization of beds and most importantly reduce the hospital stay of the patient; and also minimize their re-admission for service that could be rendered at the home care level. In essence, the potential of the VN has not been adequately tapped. There is a problem of financing this service, but there are some third party payers who do provide for this service. Admittingly, most of the payments, however, are for acute illnesses only.

(next page)

Ernest A. Byron, Jr.

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SPRINGFIELD

Special Clinics

Recently Springfield Hospital and Wesson Memorial have established concentrated programs which offer services of screening, testing and treatment of hypertension designed for patients with a higher incidence of this disease. This is an acute problem among the black population since statistics reveal that they suffer disproportionately compared to the majority. Certainly it is more urgent than sickle cell disease. It has been suggested that possibly a mobile survey group be used in churches, core area super marts and neighborhood centers to provide blood pressure determinations and disseminate visual or film education aids.

An acute problem within the core area is one of the pregnant adolescent girls. Presently, the school system operates on the policy that if a girl chooses she may enter in the early stages of pregnancy, the Pregnant Adolescent Girls Education (PAGE) program. Many of the girls have needs of a physical and psychological nature such as proper nutrition, counseling and guidance. Lastly, abortion among the minority groups is allegedly an unpopular concept based primarily on the idea of a genocide complex on the part of the recipients.

Urgent exploration for an adolescent clinic is in order not withstanding the legal limitations of parental consent and all of its implications.

The services of the mental health clinics are generally limited to everyone and the clinics are understaffed. However, the poor with all their social ills, prejudice, anxiety, degradation and hopelessness have an almost unlimited need for such services.

Continued emphasis should be given to VD thru means of visual education such as TV and the use of films.

The Neighborhood Health Center of State Street has had difficulty in making appointments in a few sub-specialties such as ophthalmology; endocrinology and dermatology. Delays of up to six; eight and twelve weeks depending on the sub specialty are reported. Unfortunately, this isn't restricted to the disadvantaged, but due to the consistent pattern of seeking service only in times of crisis or incapability, it is alleged that these delays are critical.

Perhaps these sub specialty services would be more readily available if compensation were made to the physician for cancelled appointments and if the payments for services rendered were equable.

Education

Any efforts to improve the health of the poor cannot be separated from the equal and simultaneous efforts to remove the multiple social ills such as inadequate education, the political and economic restraints currently imposed on the inner city residents. Nor will medicine be successful without basic changes in attitudes of the medical profession and hospital administrators.

Studies have shown that written materials are seldom read by those living in poverty areas. The development of visual and audio-visual aids in basic health education is paramount. Specifically such materials in nutrition, drug abuse, adolescent pregnancy, abortion, hypertension, and diabetes should be available in the language that reflects the cultural background and life style of the recipients and not the middle class values of the majority population.

Community Participation

Community participation is indispensable for the delivery of adequate health service. Consequently, a point of view that is indispensable that recruitment of individuals from disadvantaged areas with health care problems be mandatory. This lack of personnel (in certain social programs) with whom the recipient can identify may be very significant in a group who has multiple social problems from the onset, of relating to the majority.

(over)

Transportation

A prevalent complaint of the social agencies and of the elderly, particularly, is the problem of getting patients to the medical facilities at the appropriate clinic hours and physicians' office hours.

Transportation has been a problem and continues to be so. Public transportation schedules are such that they coordinate poorly with the clinic hours and other means of transportation are costly. Currently, there exists one van for the entire city operated by the combined efforts of Model Cities and Home Care Corp. for the purpose of primarily transporting the elderly to the clinic and to physicians' office for services. It has been proposed that coordination of the appointments of physicians' offices and clinics be made in order to more efficiently utilize the one van presently available.

Problems in Emergency and OPD

In the ER of hospitals where a significant number of Spanish speaking people are seen it would appear appropriate that a Spanish interpreter be available. This is a service that the hospital administrator would provide for the benefit of patient and physician as well. An inordinate amount of time is wasted in the ER and clinics trying to communicate with the patient in terms of obtaining a history, assignment of tests and follow up visits. Some of the Spanish speaking patients have great difficulty in gaining entry into the medical services which are available. A major complaint of the clinics has been that oral and printed instructions are middle class oriented; for instance, diabetic diets are based on middle class American foods which most don't consume.

The compliance behaviour is generally increased if the instructions are written in the ethnic language and the diet is composed of foods that comply with their cultural pattern. Such instruction sheets should be printed and available in the ER and clinics. There also appears to be a disparity between the physician and the patient in terms of sensitivity usually as the physician's awareness of the ethnic problems, historical background and attitudes peculiar to the patient increases the compliance behaviour of the patient does also.

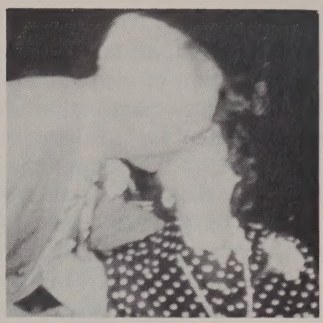
Recommendations

1. Establish mechanisms for regularly scheduled conferences in which representatives from social agencies and organizations concerned with the poor can express their views to health deliverers.
2. Develop and maintain public relations and communication mechanisms to disseminate information concerning health care services to the poor.
3. Physicians and those who participate in health delivery system must adopt new attitudes and try to understand the particular life style that is being addressed.
4. Health Education programs, like any other program, should be adapted to the socio-economic groups and life styles of students and adults and should include instructions on what constitutes good health, how to prevent illness, and how to obtain health care when needed.
5. The above mentioned program may be best handled through the local radio and television stations. Many if not most of the poor have radios and TV sets which they listen to or watch regularly and messages developed in the language and life style may offer the best means of reaching these people. Recognize the cultural variations among minority segments and develop solution appropriation to social, economic and psychological needs of each segment.
6. Maximum utilization of VNS as an adjunct to maximum utilization of hospital beds and home care encouragement.

Alonzo D. Sheffiild, M.D.

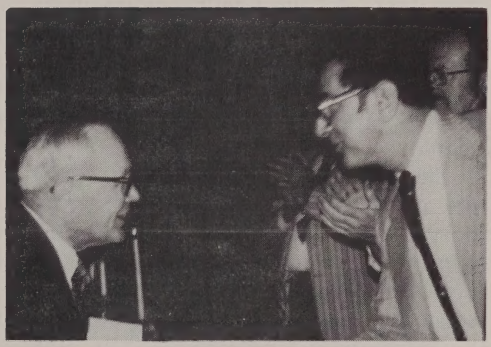
Photo Hilites from the Annual Meeting

THE NEW TEAM LEADERS



AIN'T LOVE GRAND?

NO SMOKE FILLED ROOM, THIS!



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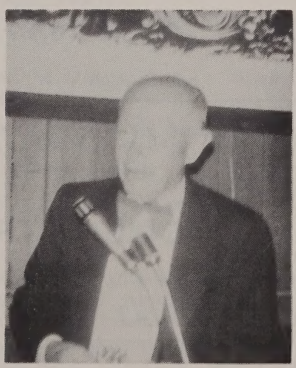

THE BOOKS BALANCED BEFORE
HE GOT HIS PRESENT.

Some welcome guidelines on death and dying

The American Medical Association, long the guardian of medical ethics, has offered physicians reasonable and welcome guidelines for dealing with the tough questions involving the dying patient. A Judicial Council report adopted by the AMA House of Delegates at last month's Clinical Convention provides wise counsel to physicians and demonstrates the Judicial Council's deliberate but well-reasoned leadership in an area that has already produced too many confusing and often controversial statements.

Setting forth clear guidelines is no easy task. As the Council notes in its report, there seems to be a consensus and agreement on the concept, but "considerable difficulty" in expressing in words what that consensus or agreement is.

The Judicial Council's report grew out of an exhaustive study of various positions and statements on the issue, consultation with its board of consultants, and a survey of state medical associations and of churches whose combined memberships include over 50% of the U. S. population. Physicians also were encouraged to voice their views. The results are perhaps the most enlightening to date. The Judicial Council found, for example, that:

(next page please)

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• There is little sentiment for euthanasia—the direct, intentional, voluntary termination of life.

• A consensus believes that, although a physician must decide which treatment is indicated and which is not, the patient needs to agree when the options are explained to him.

• Most believe that, insofar as possible, a patient's wishes regarding care in terminal illness should be respected.

• A majority feel that patients shouldn't be discouraged from indicating, in writing, their wishes regarding refusal of medical treatment during terminal illness; and these wishes should be respected, if possible, even after patients no longer are able to participate actively in decisions about their treatment.

The Judicial Council conceded that many questions still remain to be answered, and it intends to continue to provide guidance on pressing ethical issues.

AS A GUIDELINE on the question of death with dignity, the Council's recommendation adopted by the House declares:

"The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

"The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

The council encourages physicians to discuss death and terminal illness with patients, and to respect expressions of patient's wishes regarding medical care during terminal illness. However, a physician should feel free to question those wishes with a patient's legal representative or through appropriate judicial proceedings when circumstances seem to require it, the council says.

IT WOULD ALSO be well for state, county and specialty societies to heed the council's call for more discussions of the reciprocal rights and duties of physicians and of patients suffering terminal illness.

At the same time, the council cautions against the adoption of an "inflexible and even repressive" definition of death by statute. Death, it says, must be determined "by the clinical judgment of the physician using the necessary available and currently accepted criteria."

AMA News Editorial
Jan. 7, 1974

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	1973	1972	1971	3-year Compound Return
SPRINGFIELD				
First Bank	– 6.9%	+21.5%	+14.7%	+9.1%
NEW YORK				
Bank of New York	–11.2	+19.7	+19.5	+8.3
Chemical Bank	–16.3	+11.4	+25.9	+5.6
Chase Manhattan	–17.9	+ 6.5	+15.1	+0.2
First National City	–18.3	+22.4	+22.8	+7.1
Irving Trust	–18.4	+22.5	+18.8	+5.9
Manufacturers Hanover	–20.2	+25.1	+22.8	+7.0
Morgan Guaranty	–20.8	+25.9	+18.1	+5.6
U.S. Trust	–22.9	+21.9	+28.4	+6.5
Bankers Trust	–28.4	+20.5	+25.1	+2.6
S&P's 500	–14.67	+18.99	+14.35	+5.1

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A Featured Letter:

The Honorable Louis P. Bertonazzi, Chairman
Subcommittee of Committee on Social Welfare
State House
Boston, Massachusetts 02133

My dear Mr. Bertonazzi:

The legislation drafted to create Health Services Regulation Administration is a forthright manifestation of a blatant power grab for bureaucratic control of consumers and providers of health care services. Its avowed purpose is to systematically invade and takeover all traditional institutions and providers of health care services—those very institutions and providers that for many years have demonstrated their ability to achieve concrete, visible and viable results.

Physicians are not only especially singled out for takeover but even elimination where possible. The chief executive officer with virtually dictatorial powers does not have to be a physician (Section 2). Moreover, the nine member Health Services Regulation Council, which would have tremendous powers relegated to it in health affairs via the rules and regulations promulgation route, can possibly end up with only one physician thereon (Section 9). This elimination of physicians even extends to the physician's spouse who is the only provider's spouse specifically excluded in the definition of a non-provider member of the Health Services Regulation councils and boards (Section 9).

Again in the "drug formulary commission," there is a possibility of no physician member (Section 11).

The "advisory council on alcoholism" also could have a minimum to no physician representation (Section 12).

The "health personnel board" with broad advisory powers to both the boards of registration and the "health systems regulation council" would have only one physician thereon out of a total of 17 members (Section 13). This seems intellectually fraudulent since the physician is the one professional with the broadest and highest training, knowledge, skill, and judgement in the rendering of health care services and the other registered professions provide only supportive technical services. It is the physician who has the ultimate responsibility for the care of the total person.

As one reads through the proposed act creating the Health Services Regulation Administration, one can not believe that the General Court in its wisdom could delegate such broad dictatorial powers to any person or group of persons, particularly when such person or group of persons has only to answer to another bureaucratic superior. In granting the broad authority for promulgating such broad rules and regulations as defined in this proposed act, the General Court is delegating extraordinary legislative powers to a bureaucratic agency over which it has little to no control. Moreover, one might even say that the General Court is abrogating its prime "raison d'etre" by transferring its constitutionally granted legislative powers to such an agency. For instance, there is a sentence in Section 16, which reads as follows: "Each agency is said executive office may make such

(over)

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rules and regulations as it is authorized by statute to make and *may also make such rules and regulations as it may deem necessary or desirable for the exercise of its powers and the performance of its duties;* provided, that no such rule or regulation shall take effect unless the agency has complied with such rule-making procedures a said secretary may establish, pursuant to chapter thirty A, under this section." The members of the General Court must go at least every two years before their respective constituencies to make an accounting for their stewardship of a sacred trust. To what constituencies do bureaucrats go for an accounting of their stewardship?

There are many opportunities in the proposed act for such practices as coercion, intimidation, conflict of interest, favoritism, and collusion. For instance, Section 4 removes deputy administrator, assistant administrators, and superintendents of institutions as well as professionally licensed or certified personnel and others from under Civil Service.

Section 5 allows the administration to "enter into any contract and agreement necessary or desirable for the exercise of its powers or the performance of its duties." The administration can become a corporation as a trust for the receipt of moneys from any source, deposit same in interest bearing accounts, and make disbursements therefrom. Section 6 allows for tax free grants to trainees with no pre-requirements or limitations stipulated. The sections pertaining to certificate of need as well as rate and charge setting are replete with potential occasions for obnoxious practices.

Section 182, 183, 191, etc. pertaining to licensing of physicians denigrates the Board of Registration of Medicine by granting all final authority to the Health Services Regulation Administration which for all practical purposes is the administrator. Moreover, this authority in many instances is virtually autocratic and absolute.

Invasion of personal privacy is rampant and confidentiality has no guarantees whatever.

Curiously, the term "administration" is used frequently throughout connoting ultimate authority; however, when analyzed in detail "administration" is synonymous with the "administrator." The Health Services Regulation Council, which is chaired by the "administrator" can promulgate rules and regulations and only advise in all other matters. Hence, this is a matter *rule by one man* in essence.

Before I or any physician can support any statute to reorganize the health regulatory functions in the Commonwealth there must be more and better guarantees that physicians' and other providers' rights will be protected from arbitrary, capricious, discriminatory, and confiscatory administrative actions than the presently proposed act offers.

Sincerely yours,

John C. Ayres, M.D.
President-Elect
Massachusetts Medical Society

Editor's note: Dr. Ayres views and comments to the Honorable Louis P. Bertonazzi, are worthy of a wider reading, hence the featured letter.

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Poet's Corner

The following poem was read by its author, Mrs. Marion Brooks before the recent Crusade Services of the Greater Holyoke Unit of the American Cancer Society. It reflects not only its pretty author but also her dedication to one of the major Voluntary Health Organizations. All such organizations need wonderful helpers as she.—"Happiness comes from giving of oneself."

Editor-in-Chief

Hope

Let the sword of hope be bright
As it cleaves the stygian night
Bringing promise of tomorrow's rubied dawn.
When research will find the answer
To the dreaded scourge of cancer
As the war against this killer wages on.

No more to fear the ravage
Of this hydra-headed savage
Which daily claims its victims by the score.
Let leukemic babies clap
From the haven of God's lap
When tears and pain are banished, evermore.

Help continue what's been done
'Til the final battle's won—
Another giant step for man, sublime,
May our efforts we renew
Let our hoped for dream come true:
"To find the blessed cure in your lifetime."

Words by Marion Brooks
February 26, 1974
For Greater Holyoke Unit—American Cancer Society
"Miss Hope"

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Greetings

NEWS ITEM: from *The Springfield Union,* March 30, 1974

"A kiss is just a kiss, but a handshake could be the 'flu'. That's the word from Springfield's public health commissioner, Dr. John C. Ayres, who says shaking hands can be a sure way of transmitting germs, along with friendship."

I always thought of you, my dear,
As just a friend, but now I fear
If I should only shake your hand
Your husband might not understand.
So after this, when we shall meet
In public place, or on the street,
Or even far from common view—
Let's act the way we used to do!

HNS

NOTE: Can you identify this source of advice to the editor?

"In promulgating your esoteric cogitations beware of platitudinous ponderosity. Let your communication possess coalescent consistency and concatenated cogency. Eschew all flatulent garrulity and asinine affectations. Use intelligibility and veracious vivacity with rodomontade or thrasonical bombasity. Sedulously avoid all prolixity and psittaceous vacuity."

In other words, "Be intelligible, think for yourself, and be brief."

ED: Good advice to all writers.

BLACK MEN! WHITE MEN! YES, RED MEN TOO!

Apartheid thoughts may seem just the thing,
To stifle the joys of the Liberty Bell's ring.
True, those white men of old did not quite see
Their black men, the Indian men, slaves—as we
Do now . . . Know them to be . . . equal men and free.

But to revert, to ancient modes and times,
Heeding the strident voice and militant's chimes.
Will bring us all to an early, tragic grave,
Widow our wives and our children deprave.
Yes, and encourage another totalitarian wave.

Our racial biases shrink but an inch a year,
While racism expands a yard per fear.
Turn off, Slow down, Time is short, Reaction and reason slow.
Burn not, Loot not! That is OUR land now all aglow
And as always the dictum. 'Ye reap what ye sow'. . . .

Shall we then, go forward together, towards a better, fuller land
Making sure the future will see, our children—arm in hand
Sharing their destiny, not as Black . . . or White . . . or Red . . . woman or man
But as Americans. We need a renaissance, an advent for 1976 by plan,
To prove that 200 years, is only the beginning of our country's life span.

W.E.S.
3/18/69

Dear Doctor Stevens:

Is Western Massachusetts Hospital closing? This question is being asked in concerned circles. The answer is an unqualified no. Western Massachusetts Hospital is not closing. This communication is directed to you in order to put to rest rumors reinforced by recent press releases.

Indeed, the character of the hospital will change, but it will continue to serve the needs of the community. Whereas Western Massachusetts Hospital was in the past an institution primarily for the treatment of cancer, tuberculosis and chronic disease, these services will in the future be de-emphasized. Western Massachusetts Hospital is being restructured to offer comprehensive rehabilitation services. As you know, physical rehabilitation has been an integral part of this hospital's services for the past two years. These services will be expanded to encompass physical rehabilitation for the multiple handicapped child.

An alcoholic rehabilitation program will hopefully soon begin. Western Massachusetts Hospital does not intend to develop an alcoholic detoxification center, nor will it offer services for the treatment of drug addiction.

The Wednesday Surgical Clinic will continue, as will all other clinical services. At the Executive Committee meeting, held on the 3rd of April, most consultants felt that we had a moral obligation to those patients we have treated over the past twenty or more years, and decided to continue to follow them. The future of the surgical services has not been decided. As soon as a decision has been reached, you will be informed.

Dr. Klautky or myself would be happy to answer any further questions.

Helen Harmand, M.D.
Superintendent

Dear Dr. Stevens:

I am writing you as per your request to comment on the letter of Dr. Walter Tauber published in the February Hippocrat. We have had all the problems described by Dr. Tauber and they continue to plague us without cease. After a particularly distressing series of computer reports from the Department of Public Welfare on November 18, 1973, I wrote the Honorable Anthony Scibelli on December 18, 1973. He turned the letter over to Mr. Minter, and a copy of Mr. Minter's reply is enclosed. More than thirty days have now passed since the letter, and the improvement promised has proved futile. I am about to write Mr. Minter and Mr. Scibelli again, but I have very little hope.

It would appear that the government has little concern for the governed for, obviously, "the extensive manual handling" in doctor's offices throughout the commonwealth far exceeds the activities within the Department of Public Welfare.

It is now my practice in this office to follow the advice of Mr. Jones of the local Welfare office and refuse to see any patient who claims to be on Welfare, but does not have a current Welfare card. This discrimination against an important segment of our society perpetrated by the Department of Public Welfare seems most regrettable.

Sincerely,
Gary deN. Hough, III, M.D.

(see following letter)

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RE: Your inquiry of December 18, 1973, to the Honorable Anthony M. Scibelli

Dear Dr. deN. Hough:

Representative Scibelli has given me a copy of your recent letter regarding the handling of your claims, some of which were reported back to you as "case unknown." I am aware of the difficulty these "cases unknown" may present to your bill-posting procedures; however, my people have reviewed in detail, other alternatives, and their implications for handling these cases, and found this method to be the only workable solution. Other alternatives require extensive manual handling by our claims control personnel, which becomes prohibitive in terms of magnitude of cases and time to be expended.

However, I can assure you that searches have been made to reduce these "cases unknown" to the minimum before returning the remainder to you. This was accomplished by modifying our computerized master file so that we could access the correct case for eligibility determination with only an accurate nine-digit social security number. This means that even though an error might have been input for the region, office, category, or check digit code, we still would have located the record based only on a correct social security number. This modification, which, by the way, required several man-months of time by our computer staff, did reduce the number of "cases unknown" that we might have initially sent you by over fifty-five percent. However, we *must* have at least a correct nine-digit social security number.

As mentioned in my November 9, 1973 letter, we are presently, and will continue to take steps to reduce key entry errors which are responsible for some of these "case unknown" claims. We have further refined our check digit program and our key entry procedures to further reduce the social security numbers that our personnel read or enter in error. The check digit, which is the tenth digit of the social security number, represents an arithmetical check of the preceding nine digits. If any of these nine digits are entered incorrectly, the computed check digit will disagree with the entered check digit reported by you, which was taken from the Medical Eligibility Card. When this check indicates an error, we take immediate steps to correct the number. At the present, incorrect numbers that enter the system because of an incorrect or missing check digit or missing suffix, cannot be automatically corrected at the point of entry and often become "cases unknown." Within the next 30 days, we will have additionally modified our system to permit the key entry of the alphabetical name in those cases where the check digit test fails or is missing. Our computer can then at least give you the name which you provided us on the claim form. This change should virtually eliminate the need for reporting "case unknown"; however, it will not eliminate the disallowance for case not on file.

We have an individual consideration procedure for those fees which you feel warrant payment higher than provided in the existing fee schedule. If you feel that certain professional fees are not equitable for the service you are providing, you may request a reconsideration by our Medical Division. This requires written notice to the Welfare Service Office along with copies of invoices, medical or operative reports, etc., as indicated, for review. These requests will be forwarded to the Medical Division for review and necessary redetermination.

Please understand the tremendous volume of claims we receive each day which preclude, to any significant extent, individual attention to each. Our Department must depend upon computers to handle the bulk of the processing of these 18 thousand claims each day; however, my people are always happy to provide individual attention to those claims which are unique.

Very truly yours,

Steven A. Minter
Commissioner

Dear Mr. Administrator:

The Executive Committee of the Hampden District Medical Society has received numerous complaints in regard to newspaper and television medical news releases in this area. The complaints have been directed toward the physicians and hospitals for misleading articles and reports. It is our suggestion that in order to prevent future misunderstanding that Public Relation men of the hospitals must check with corresponding physicians prior to release of any material to the news media.

The Hampden District Executive Committee and the Executive Secretary stands ready to assist with any problem. We believe that it is to the best interest of the community that we work together closely in this matter. As you know the medical profession and the hospitals have been under a lot of pressure and criticism. The Executive Committee would like to hear comments from you.

Sincerely yours,
Augusto Asinas, M.D., Chairman
Public Relations Committee

Ed's note: This letter went to all hospitals within Hampden District.

Dear Sir:

The Hampden Hippocrat has published, in its March issue, a letter by Dr. Peter G. Sellei, in which he presented his opposition to some proposed state regulations for hospitals offering cancer treatment and for hospitals with emergency facilities.

Among other factors included for purposes of classification is the existence of a teaching program in the hospital concerned. As for Emergency Treatment Facilities, they would be considered "Comprehensive" when backed by operating facilities ready "at all hours, including an anesthetist in the hospital and available within 5 minutes," by the presence of cardiopulmonary bypass facilities, and by in-house coverage by physicians who have had at least two years of residency training in surgery, medicine, and anesthesiology.

Admittingly, these standards are difficult and expensive to achieve, but they deserve hardly to be defined "useless" and be denied discussion in our community. Two easy examples of pathology where success is directly related to the speed of surgical intervention are patients with severe intracavitary arterial bleeding and patients with sudden extreme increase of intracranial pressure. As for the bypass capabilities, whatever the chances of survival may be for the patient recovering from trauma with an unrecognized rupture of the thoracic aorta which then becomes symptomatic, or for the patient dying in shock from coronary occlusion, a pump team 50 miles away should not be considered the adequate answer for a large community of potential users.

(cont. on next page)

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Dr. Sellei's beliefs that, in the treatment of cardiorespiratory arrest, no lives can be saved by the in-hospital presence of an efficient team of physicians, and that cardiorespiratory resuscitation is successful only in the operating room, are in contrast with what is being achieved at the national and local levels.

May I refer the reader to one of the very many articles which have appeared in the past decade: J. G. Lemire & AA "Is Cardiac Resuscitation Worthwhile? A Decade of Experience" N Engl J Med 286: 970-972. Of the 1,204 patients resuscitated by a mobile team in a large general teaching hospital, the overall survival rate—discharged from the hospital—was 19%. Quoting from the editorial on the same issue of the Journal, this "is a challenge to every physician, nurse, and hospital in the land." On a local basis, in 1972 the average long term survival rate of patients in cardiac arrest treated by the Code Blue Team of the Springfield Hospital Medical Center was 16%. These data do not ignore the essential contribution to be given, in and out of the hospital, by the well trained first person on the scene, presumably not a physician. What the data prove is that only immediate follow-up by a multi-specialty team of physicians can cope with these complex emergencies and produce long-lasting survivals.

In his comparison with the non-teaching community hospitals, Dr. Sellei lumps together and confuses functions, cost, and efficiency of the teaching community hospitals and the university hospitals. The concept that it is uneconomical for society to increase the clinical load of the university hospital beyond its necessities for teaching and research is not in question. Instead, in the case of the teaching community hospital, the evidence favors the opposite concept that optimal care is achieved there at favorable cost. Teaching community hospitals show productivity comparable with non-teaching hospitals of the same size. At the same time, they offer to the community the type and quality of services that can be achieved only in and by the presence of a multi-specialty training program.

Our community should face the issues of the proposed regulations for what they are, in the context of the present medical reality. The optimal treatment of diseases and accidents is getting more and more sophisticated and expensive, with success, at least at the more complex level, just not attainable otherwise. This is what is behind the proposed regulations and to shift the issue to the legitimate but non-germane field of free enterprise versus state control will not help.

Close cooperation or even integration between institutions in their pursuit of excellence, different as they may be in some aspect, should be our way to answer the challenge.

Franco R. Dinale, M.D
Anesthesiologist-in-Chief

Editor's Note: A good and different viewpoint. The Hippocrat's pages welcome further comment.

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Letters to the Editor (cont.)

Dear Dr. Zacarian,

For the past twenty years WWLP Channel 22 has conferred its "Outstanding Servant of the Public" awards on area residents who have made exceptional contributions to the community.

This year it is our pleasure to call attention to your performance in the service of the public by presenting one of our 1974 awards to you. Please accept our sincere congratulations.

Our plans call for a special presentation telecast from our Provin Mountain studios in Agawam on Tuesday, June 4, at 7:30 p.m. The program will be seen over Channels 22 and 32, and during this program you and the other recipients will receive your awards.

We sincerely hope that you will be at our studios at 5:30 p.m. for a reception, with dinner at six. We will then have a brief rehearsal before the live telecast at 7:30. You are cordially invited to bring Mrs. Zacarian or a guest of your choice.

Meanwhile, will you be so kind as to send to our Public Relations Director, Bob Donahue, biographical material about yourself, such as a chronological rundown of your community service, place of birth, education, professional, fraternal or service organizations, etc.

We all look forward to meeting with you on June 4.

Sincerely,
William L. Putnam

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INFLATION

TO MEET THE RISING COSTS OF PUBLICATION, MORE ADS ARE NEEDED. CONTACT MRS. WILLARD WITH YOUR IDEAS OR SOURCES.

To: Censors of Hampden District.

From: Malcolm S. Allan, M.D., Supervisory Censor.

The Censors will meet on Thursday, May 2, 1974 at 5:3; P.M. at the society office at 1414 State Street.

The following candidates will be examined: Adly Habib Iskandar, M.D.; Richard Joseph Miller, M.D.; Barry Franklin Sachs, M.D.; Peter George Sellei, M.D.; Leroy Shear, M.D.; Peter Benjamin Wasserman, M.D.

Sent to the following Censors: Drs. Allan, John J. Burke, John J. Flahive, H. Bernard Tillman, Robert J. Bye, Setrag A. Zacarian, Walton E. Stevens and Bernard Bloom.

Editors Note: All candidates were approved by the Censors. Their applications will now be forwarded to the M.M.S.

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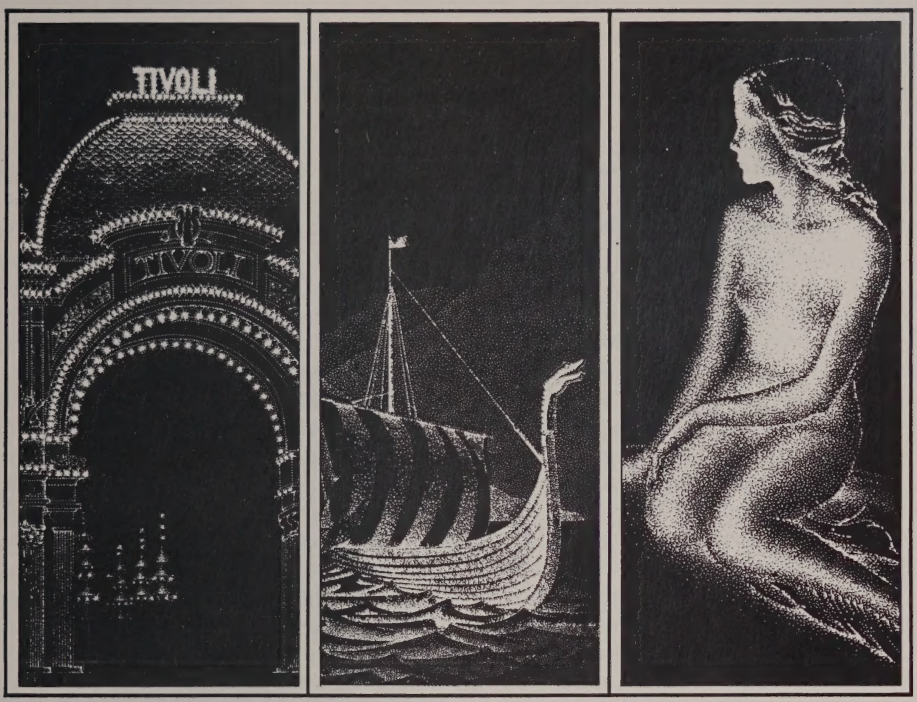

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EDITORIAL:

Comments on Some of the Issues Facing the HDMS Officers

The past two years of stewardship as Secretary of the Hampden District Medical Society, has given the Editor-in-Chief a unique vantage point from which to make, record and comment upon current and past happenings, which have or will effect the practice of medicine in this district. These comments are not meant to be dictatorial, but are to serve as the nidus for ferment and discussion. The reader is invited to contribute his or her own ideas or comments and thereby give guidance to the officers.

Five major topics were chosen: 1) Membership, 2) Finances, 3) Legislation, 4) Patient Care and 5) Public and Professional Relations. Each topic had many subdivisions, only a few will be hilighted. The Hampden District Medical Society, along with its sister districts and its parent the Massachusetts Medical Society, must develop and present *positive* policies and programs to meet the public and political demands to improve the delivery of Health Care. To pat ourselves on our backs and say that only physicians know what is best and to further ignore the indictments from our patients, invites disaster in the form of a National Health *System.* We should be developing a National Health *Insurance Program* tailored to the patients' needs and our ability to deliver the needed care. Prevention of illness and accidents and the restoration of health must be our first goal of practice.

Membership: The Hampden District Medical Society comprises 87.6% of the licensed and practicing physicians in its district, of whom only 66.0% belong to the A.M.A. The ostrich philosophy for not joining results in a kick in the rump by our enemies, of whom we have many! In this democratic republic action is obtained

(cont.)

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by joining, participating and voting its will as a majority. Non-participation is self-castigation and the symbolism of the original Roman Senate prevails. Thus it behooves us all to join, close ranks behind the leaders of organized medicine at all three levels, i.e. district, state and national.

The new and young physicians entering the district society are most welcome. Our officials and membership must *extend* themselves to have them participate actively in society affairs and to solicit their opinions on all problems and issues. The evolutionary forces of medicine will most often be found in their idealism!

Perhaps the "Buddy System" would be applicable to boost the membership's attendance at the District's meetings. Certainly those physicians who sponsored a new member should bring that new member to his first few meetings, so that he learns his way about and meets some follow new-members. There is no reason that an active member can not stop to bring a more mature physician who may no longer care to drive in alone.

The final issue dealing with membership is one which would help to "bring us all together." Each district hospital mounts an educational and scientific program for its staff and to meet JCAH regulations. Physicians with multiple staff appointments or even one with a single hospital affiliation have far too many such meetings with required attendance. Often conflicts in scheduling or timing occur which prevent a physician going to a meeting in a hospital to which he is not a staff member. Centralization of the scientific programs to one or two a month to which all physicians could go and receive both C.M.E. and staff credit seems best. The approach could be either multidisciplinary for some subjects and speciality oriented for others. The Springfield Academy of Medicine might well serve as the coordinating agency.

(over)

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Finances: The problem of inflation presents many issues to be faced by both physician and hospital. Hospitals usually have expert legal and financial assistance readily available, the physician does not. His mail brings him conflicting advice and suggestions of what to do. Would the membership be benefited if the HDMS would organize a socio-economic roundtable or symposium? Could and would enough physicians take a ½ day off, to listen to a panel of experts prepared to discuss local problems?

National Health Insurance is coming—hopefully it will not be a National Health System. Payment for services rendered or to be rendered (prepay HMO) will be increasingly from the third party payor, not our patients. The District and State societies must assist the physician in jockeying for the best and most advantageous position before the fact of NHI. Input and exchange with the Blues and other carriers as to what is best for both is essential.The A.M.A.has collated much data in this area and use should be made thereof. It can provide a national overlook and indicate the good and bad features of other state plans. Medicine and organized medicine must be in a position of strength. Few physicians are capable of continuing their practices without continuing income and a strike or mass-individual refusal to participate would only see the Quebec debacle repeated in Massachusetts. No state will allow a group to threaten the wellbeing of its citizens. Our leaders must form the necessary study groups and begin negotiations at the district level.

The Rate Setting Commission and the Insurance Commissioner need to be assessed and provided with reasonable arguments supporting the need to improve or stabilize disbursements from State programs and coffers. An amicable co-existence is essential for financial security!

The last issue of this topic is really a posed provocative question, which can be an issue if the new medical administration so cares. Does the HDMS and/or the MMS need a war chest, lobby fund or a sinking fund with which to provide legal aid, protection and guidance in the writing of the *regulations* of the NHI and those of the State's Department of Public Health? Assessments would be necessary to mount such a fund.

(cont.)

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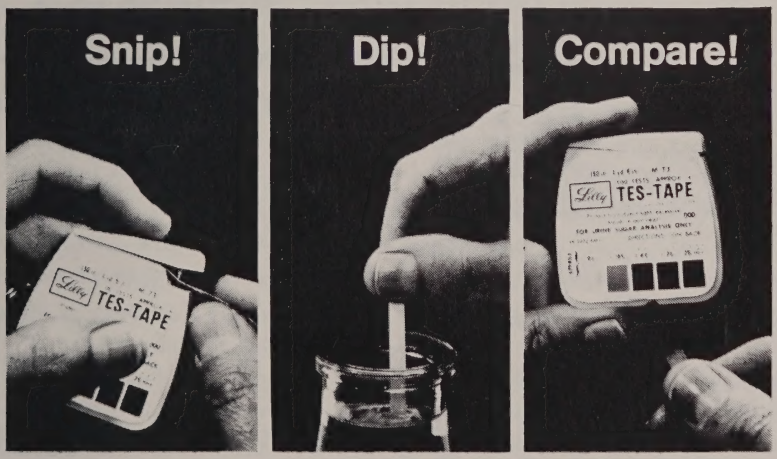
Legislation: Two issues exist on the state level. The first is the need to change the medical licensure act to conform to standards of ethics and medical conduct applicable to the 1970's and 1980's. For repeated offenses, less than felonies, but of unethical and amoral acts the ranks of medicine should be able to purge itself of such perpetrators. Society sees a wrong then blames our district for not correcting it; society does not understand that we have no jurisdiction or power to punish. What is needed is a fair method to stop a physician from practicing when his peers judge him to be acting against the best interests of the patient or society. The second issue concerns itself with the relationship that the HDMS and MMS should have with the Department of Public Health. The proper selection of advisory committees (to prevent conflict of interest) is absolute so that the State and organized medicine do not again come to suit. The proposed Cancer R & R are but an example of our need to assist the DPH.

At the national level, the major issue is the impending National Health Insurance Program. Input is essential. PSRO and HMO legislation exists and our energies must be directed to modifying or amending the law to make it more workable for us and our patients. The medical profession must give positive, purposeful and progressive proposals and stop just saying "No, the old way is better!"; even if it is. Letters to our legislators with copies to the MMS, stating our thoughts and opinions should be written now, not two days before an issue becomes a crisis and emotion exceeds sound objectives.

(To be continued next month)

W. E. Stevens, M.D.



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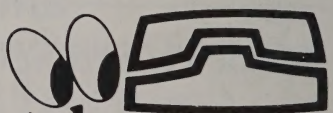

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